



CONNECTICUT
HOSPITAL
ASSOCIATION

**TESTIMONY OF
CONNECTICUT HOSPITAL ASSOCIATION
SUBMITTED TO THE
HUMAN SERVICES COMMITTEE
Thursday, March 1, 2012**

**SB 30, An Act Implementing Provisions Of The Budget
Concerning Human Services**

The Connecticut Hospital Association (CHA) appreciates this opportunity to submit testimony concerning **SB 30, An Act Implementing Provisions Of The Budget Concerning Human Services**. CHA believes the changes proposed in Section 3 of the bill as drafted do not go far enough to address the open issues with the hospital tax and DSH program adopted last year by the legislature.

Before outlining our concerns, it's important to detail the critical role hospitals play in the health and quality of life of our communities. Our state's hospitals are more than facts and figures, and dollars and cents. Hospitals, at their core, are all about people. All of our lives have, in some way, been touched by a hospital: through the birth of a child, a life saved by prompt action in an emergency room, or the compassionate end-of-life care for someone we love. Or perhaps our son, daughter, husband, wife, or friend works for, or is a volunteer at, a Connecticut hospital.

Hospitals provide care to all people regardless of their ability to pay. In fact, every three minutes, someone without health insurance comes to a Connecticut hospital in need of inpatient, emergency, or outpatient surgical services. Connecticut hospitals are the ultimate safety net providers and offer care 24 hours a day, seven days a week, 365 days a year.

Every day, healthcare professionals in hospitals see the consequences and health implications for individuals and families who lack access to care and coverage. Emergency departments are filled with individuals who cannot find a physician to care for them because they are uninsured or underinsured – or they are Medicaid beneficiaries and few physicians will accept the low rates paid by Medicaid. Throughout Connecticut, our emergency rooms are treating both those who have delayed seeking treatment because of inadequate or no coverage, and those who have no other place to receive care.

Thus, as frontline caregivers, Connecticut hospitals are absolutely committed to initiatives that improve access to high quality care and expand health insurance coverage. Connecticut hospitals stand ready to partner on solutions to create a system of healthcare coverage that ensures access to all residents. Such a system must ensure seamless coordinated care that is affordable to individuals and families, and is sufficiently financed. The ultimate goal is to establish a healthcare system through which coverage is affordable and sustainable, and access to care is guaranteed.

CHA believes Section 3 of SB 30 should address four issues. It should: 1) clarify that the interim DSH and supplemental payments by hospital for the 27-month period from July 1, 2011, to September 30, 2013, remain the same; 2) clarify that the tax rates, tax amounts, and tax exemptions remain the same for the 27-month period from July 1, 2011, to September 30, 2013; 3) require the Department of Social Services (DSS) to engage the independent auditor necessary to complete the Disproportionate Share Hospital (DSH) audits, and require the DSH audits be completed within 15 months of the close of a hospital's fiscal year; and 4) limit DSH redistributions determined pursuant to the DSH audit to only those required by federal law, i.e., amounts that exceed the federal Upper Payment Level (UPL).

Subsection (b) of Section 17b-239c of the 2012 supplement to the general statutes provides that the basis of DSH payment for the 15-month period beginning July 1, 2011, would be 2009 data. This section further required that DSH payment for subsequent hospital fiscal years would be based on the most recent data available, e.g., DSH payment for October 1, 2012, would be based on 2011 data. To implement this schedule, hospitals, the administration, and the legislature would need to engage now to determine the impact by hospital as well as how to mitigate any additional financial harm that would occur because of updating the data used to determine interim payments. Given how difficult it is to manage these changes, the hospitals prefer to have the current taxes, payment, and exemptions for 27 instead of 15 months. The language proposed by the administration in SB 30 locks in the payments for 27 months – it does not lock in the tax and exemptions for 27 months. Having interim payments locked while taxes and exemptions float would change the impact by hospital. Based on our discussions with the administration, we understand they intend to lock the payments, taxes, and exemptions. We have offered language, attached, that would capture that intention in statute.

Fixing the payment, tax, and exemptions for 27 months solves one problem, i.e., what will happen on an interim basis for that 27-month period. It does not resolve how much of those payments a hospital will be able to keep. How much a hospital can keep is determined under federal rules by a final DSH audit done by an independent auditor hired by the state. It is our understanding that DSS intends to complete a year's DSH audit three years and three months after the close of a year. This schedule is just not workable – at that pace, \$1.3 billion in DSH payments would have been paid on an interim basis before we have an idea how close the interim payments are to the final. Getting the answer sooner is not difficult, but it does require DSS to hire the auditor and move up the timeframe to within 15 months of the close of a hospital year. We have attached language to accomplish more timely DSH audits.

In addition to completing DSH audits sooner, hospitals need certainty about what will cause redistribution as a result of that audit. DSS has said it will limit DSH audit adjustments at settlement to only those amounts that exceed the UPL. However, DSS has filed a state plan amendment with Centers for Medicare and Medicaid Services (CMS) that says DSH audit adjustments at settlement can be limited to amounts that exceed the UPL and can also include amounts to reconcile the data between estimated and final. The hospitals are unanimous that DSH audit redistribution should be limited to the former, which is what is required by federal law, and not include the latter – which is not required by federal law. We have attached language to capture in statute the specificity necessary to limit DSH reconciliations to only those amounts required under federal law.

Thank you for your consideration of our position. For additional information, contact Stephen Frayne, Senior Vice President, Health Policy at (203) 294-7280.

Attachment

Sec. XX Subsection (a) of Section 12-263b of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) For each calendar quarter commencing on or after July 1, 2011, there is hereby imposed a tax on the net patient revenue of each hospital in this state to be paid each calendar quarter. The rate of such tax shall be up to the maximum rate allowed under federal law. The Commissioner of Social Services shall determine the base year on which such tax shall be assessed. The Commissioner of Social Services may, in consultation with the Secretary of the Office of Policy and Management and in accordance with federal law, exempt a hospital from the tax on payment earned for the provision of outpatient services based on financial hardship. Effective July 1, 2012 and for the succeeding twenty-seven months, the rates of such tax, the base year on which such tax shall be assessed, and the hospitals exempt from the outpatient portion of the tax based on financial hardship shall be the same tax rates, base year, and outpatient exemption for hardship in effect on January 1, 2012.

Sec. XX. Subsection (b) of section 17b-239c of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) Effective July 1, 2011, interim payments made to hospitals pursuant to this section for the succeeding [fifteen] twenty-seven months shall be based on 2009 federal fiscal year data and may be adjusted at the commissioner's discretion for accuracy. Effective October 1, [2012,] 2013, subsequent interim payments shall be based on the most recent federal fiscal year data available. For federal fiscal year 2011 and succeeding federal fiscal years, final disproportionate share payment amounts shall be recalculated and reallocated in accordance with Section 1001(d) of Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The DSH settlement will be limited to reductions for those hospitals over the hospital specific DSH limit with a reallocation to the other hospitals. The amount of any DSH settlement due from or to hospitals shall be determined by the commissioner within fifteen months of the close of each hospital fiscal year. The commissioner shall prescribe uniform annual hospital data reporting forms. Payments made pursuant to this section shall be in addition to inpatient hospital rates determined pursuant to section 17b-239. The commissioner may withhold payment to a hospital to offset money owed by the hospital to the state.